



Senate

General Assembly

File No. 176

February Session, 2008

Substitute Senate Bill No. 482

Senate, March 26, 2008

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH CARE CLAIMS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-816 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective January 1, 2009*):

3 The following are defined as unfair methods of competition and
4 unfair and deceptive acts or practices in the business of insurance:

5 (1) Misrepresentations and false advertising of insurance policies.
6 Making, issuing or circulating, or causing to be made, issued or
7 circulated, any estimate, illustration, circular or statement, sales
8 presentation, omission or comparison which: (a) Misrepresents the
9 benefits, advantages, conditions or terms of any insurance policy; (b)
10 misrepresents the dividends or share of the surplus to be received, on
11 any insurance policy; (c) makes any false or misleading statements as
12 to the dividends or share of surplus previously paid on any insurance
13 policy; (d) is misleading or is a misrepresentation as to the financial
14 condition of any person, or as to the legal reserve system upon which

15 any life insurer operates; (e) uses any name or title of any insurance
16 policy or class of insurance policies misrepresenting the true nature
17 thereof; (f) is a misrepresentation, including, but not limited to, an
18 intentional misquote of a premium rate, for the purpose of inducing or
19 tending to induce to the purchase, lapse, forfeiture, exchange,
20 conversion or surrender of any insurance policy; (g) is a
21 misrepresentation for the purpose of effecting a pledge or assignment
22 of or effecting a loan against any insurance policy; or (h) misrepresents
23 any insurance policy as being shares of stock.

24 (2) False information and advertising generally. Making, publishing,
25 disseminating, circulating or placing before the public, or causing,
26 directly or indirectly, to be made, published, disseminated, circulated
27 or placed before the public, in a newspaper, magazine or other
28 publication, or in the form of a notice, circular, pamphlet, letter or
29 poster, or over any radio or television station, or in any other way, an
30 advertisement, announcement or statement containing any assertion,
31 representation or statement with respect to the business of insurance
32 or with respect to any person in the conduct of his insurance business,
33 which is untrue, deceptive or misleading.

34 (3) Defamation. Making, publishing, disseminating or circulating,
35 directly or indirectly, or aiding, abetting or encouraging the making,
36 publishing, disseminating or circulating of, any oral or written
37 statement or any pamphlet, circular, article or literature which is false
38 or maliciously critical of or derogatory to the financial condition of an
39 insurer, and which is calculated to injure any person engaged in the
40 business of insurance.

41 (4) Boycott, coercion and intimidation. Entering into any agreement
42 to commit, or by any concerted action committing, any act of boycott,
43 coercion or intimidation resulting in or tending to result in
44 unreasonable restraint of, or monopoly in, the business of insurance.

45 (5) False financial statements. Filing with any supervisory or other
46 public official, or making, publishing, disseminating, circulating or
47 delivering to any person, or placing before the public, or causing,

48 directly or indirectly, to be made, published, disseminated, circulated
49 or delivered to any person, or placed before the public, any false
50 statement of financial condition of an insurer with intent to deceive; or
51 making any false entry in any book, report or statement of any insurer
52 with intent to deceive any agent or examiner lawfully appointed to
53 examine into its condition or into any of its affairs, or any public
54 official to whom such insurer is required by law to report, or who has
55 authority by law to examine into its condition or into any of its affairs,
56 or, with like intent, wilfully omitting to make a true entry of any
57 material fact pertaining to the business of such insurer in any book,
58 report or statement of such insurer.

59 (6) Unfair claim settlement practices. Committing or performing
60 with such frequency as to indicate a general business practice any of
61 the following: (a) Misrepresenting pertinent facts or insurance policy
62 provisions relating to coverages at issue; (b) failing to acknowledge
63 and act with reasonable promptness upon communications with
64 respect to claims arising under insurance policies; (c) failing to adopt
65 and implement reasonable standards for the prompt investigation of
66 claims arising under insurance policies; (d) refusing to pay claims
67 without conducting a reasonable investigation based upon all available
68 information; (e) failing to affirm or deny coverage of claims within a
69 reasonable time after proof of loss statements have been completed; (f)
70 not attempting in good faith to effectuate prompt, fair and equitable
71 settlements of claims in which liability has become reasonably clear;
72 (g) compelling insureds to institute litigation to recover amounts due
73 under an insurance policy by offering substantially less than the
74 amounts ultimately recovered in actions brought by such insureds; (h)
75 attempting to settle a claim for less than the amount to which a
76 reasonable man would have believed he was entitled by reference to
77 written or printed advertising material accompanying or made part of
78 an application; (i) attempting to settle claims on the basis of an
79 application which was altered without notice to, or knowledge or
80 consent of the insured; (j) making claims payments to insureds or
81 beneficiaries not accompanied by statements setting forth the coverage
82 under which the payments are being made; (k) making known to

83 insureds or claimants a policy of appealing from arbitration awards in
84 favor of insureds or claimants for the purpose of compelling them to
85 accept settlements or compromises less than the amount awarded in
86 arbitration; (l) delaying the investigation or payment of claims by
87 requiring an insured, claimant, or the physician of either to submit a
88 preliminary claim report and then requiring the subsequent
89 submission of formal proof of loss forms, both of which submissions
90 contain substantially the same information; (m) failing to promptly
91 settle claims, where liability has become reasonably clear, under one
92 portion of the insurance policy coverage in order to influence
93 settlements under other portions of the insurance policy coverage; (n)
94 failing to promptly provide a reasonable explanation of the basis in the
95 insurance policy in relation to the facts or applicable law for denial of a
96 claim or for the offer of a compromise settlement; (o) using as a basis
97 for cash settlement with a first party automobile insurance claimant an
98 amount which is less than the amount which the insurer would pay if
99 repairs were made unless such amount is agreed to by the insured or
100 provided for by the insurance policy.

101 (7) Failure to maintain complaint handling procedures. Failure of
102 any person to maintain complete record of all the complaints which it
103 has received since the date of its last examination. This record shall
104 indicate the total number of complaints, their classification by line of
105 insurance, the nature of each complaint, the disposition of these
106 complaints, and the time it took to process each complaint. For
107 purposes of this subsection "complaint" shall mean any written
108 communication primarily expressing a grievance.

109 (8) Misrepresentation in insurance applications. Making false or
110 fraudulent statements or representations on or relative to an
111 application for an insurance policy for the purpose of obtaining a fee,
112 commission, money or other benefit from any insurer, producer or
113 individual.

114 (9) Any violation of any one of sections 38a-358, 38a-446, 38a-447,
115 38a-488, 38a-825, 38a-826, 38a-828 and 38a-829. None of the following

116 practices shall be considered discrimination within the meaning of
117 section 38a-446 or 38a-488 or a rebate within the meaning of section
118 38a-825: (a) Paying bonuses to policyholders or otherwise abating their
119 premiums in whole or in part out of surplus accumulated from
120 nonparticipating insurance, provided any such bonuses or abatement
121 of premiums shall be fair and equitable to policyholders and for the
122 best interests of the company and its policyholders; (b) in the case of
123 policies issued on the industrial debit plan, making allowance to
124 policyholders who have continuously for a specified period made
125 premium payments directly to an office of the insurer in an amount
126 which fairly represents the saving in collection expense; (c)
127 readjustment of the rate of premium for a group insurance policy
128 based on loss or expense experience, or both, at the end of the first or
129 any subsequent policy year, which may be made retroactive for such
130 policy year.

131 (10) Notwithstanding any provision of any policy of insurance,
132 certificate or service contract, whenever such insurance policy or
133 certificate or service contract provides for reimbursement for any
134 services which may be legally performed by any practitioner of the
135 healing arts licensed to practice in this state, reimbursement under
136 such insurance policy, certificate or service contract shall not be denied
137 because of race, color or creed nor shall any insurer make or permit
138 any unfair discrimination against particular individuals or persons so
139 licensed.

140 (11) Favored agent or insurer: Coercion of debtors. (a) No person
141 [may] shall (i) require, as a condition precedent to the lending of
142 money or extension of credit, or any renewal thereof, that the person to
143 whom such money or credit is extended or whose obligation the
144 creditor is to acquire or finance, negotiate any policy or contract of
145 insurance through a particular insurer or group of insurers or
146 producer or group of producers; (ii) unreasonably disapprove the
147 insurance policy provided by a borrower for the protection of the
148 property securing the credit or lien; (iii) require directly or indirectly
149 that any borrower, mortgagor, purchaser, insurer or producer pay a

150 separate charge, in connection with the handling of any insurance
151 policy required as security for a loan on real estate or pay a separate
152 charge to substitute the insurance policy of one insurer for that of
153 another; or (iv) use or disclose information resulting from a
154 requirement that a borrower, mortgagor or purchaser furnish
155 insurance of any kind on real property being conveyed or used as
156 collateral security to a loan, when such information is to the advantage
157 of the mortgagee, vendor or lender, or is to the detriment of the
158 borrower, mortgagor, purchaser, insurer or the producer complying
159 with such a requirement. (b)(i) Subsection (a)(iii) does not include the
160 interest which may be charged on premium loans or premium
161 advancements in accordance with the security instrument. (ii) For
162 purposes of subsection (a)(ii), such disapproval shall be deemed
163 unreasonable if it is not based solely on reasonable standards
164 uniformly applied, relating to the extent of coverage required and the
165 financial soundness and the services of an insurer. Such standards
166 shall not discriminate against any particular type of insurer, nor shall
167 such standards call for the disapproval of an insurance policy because
168 such policy contains coverage in addition to that required. (iii) The
169 commissioner may investigate the affairs of any person to whom this
170 subsection applies to determine whether such person has violated this
171 subsection. If a violation of this subsection is found, the person in
172 violation shall be subject to the same procedures and penalties as are
173 applicable to other provisions of section 38a-815, subsections (b) and
174 (e) of section 38a-817 and this section. (iv) For purposes of this section,
175 "person" includes any individual, corporation, limited liability
176 company, association, partnership or other legal entity.

177 (12) Refusing to insure, refusing to continue to insure or limiting the
178 amount, extent or kind of coverage available to an individual or
179 charging an individual a different rate for the same coverage because
180 of physical disability or mental retardation, except where the refusal,
181 limitation or rate differential is based on sound actuarial principles or
182 is related to actual or reasonably anticipated experience.

183 (13) Refusing to insure, refusing to continue to insure or limiting the

184 amount, extent or kind of coverage available to an individual or
185 charging an individual a different rate for the same coverage solely
186 because of blindness or partial blindness. For purposes of this
187 subdivision, "refusal to insure" includes the denial by an insurer of
188 disability insurance coverage on the grounds that the policy defines
189 "disability" as being presumed in the event that the insured is blind or
190 partially blind, except that an insurer may exclude from coverage any
191 disability, consisting solely of blindness or partial blindness, when
192 such condition existed at the time the policy was issued. Any
193 individual who is blind or partially blind shall be subject to the same
194 standards of sound actuarial principles or actual or reasonably
195 anticipated experience as are sighted persons with respect to all other
196 conditions, including the underlying cause of the blindness or partial
197 blindness.

198 (14) Refusing to insure, refusing to continue to insure or limiting the
199 amount, extent or kind of coverage available to an individual or
200 charging an individual a different rate for the same coverage because
201 of exposure to diethylstilbestrol through the female parent.

202 (15) (A) Failure by an insurer, or any other entity responsible for
203 providing payment to a health care provider pursuant to an insurance
204 policy, to pay accident and health claims, including, but not limited to,
205 claims for payment or reimbursement to health care providers, within
206 the time periods set forth in subparagraph (B) of this subdivision,
207 unless the Insurance Commissioner determines that a legitimate
208 dispute exists as to coverage, liability or damages or that the claimant
209 has fraudulently caused or contributed to the loss. Any insurer, or any
210 other entity responsible for providing payment to a health care
211 provider pursuant to an insurance policy, who fails to pay such a claim
212 or request within the time periods set forth in subparagraph (B) of this
213 subdivision shall pay the claimant or health care provider the amount
214 of such claim plus interest at the rate of fifteen per cent per annum, in
215 addition to any other penalties which may be imposed pursuant to
216 sections 38a-11 of the 2008 supplement to the general statutes, 38a-25,
217 38a-41 to 38a-53, inclusive, 38a-57 to 38a-60, inclusive, 38a-62 to 38a-64,

218 inclusive, 38a-76, 38a-83, 38a-84, 38a-117 to 38a-124, inclusive, 38a-129
219 to 38a-140, inclusive, 38a-146 to 38a-155, inclusive, 38a-283, 38a-288 to
220 38a-290, inclusive, 38a-319, 38a-320, 38a-459, 38a-464, 38a-815 to 38a-
221 819, inclusive, 38a-824 to 38a-826, inclusive, and 38a-828 to 38a-830,
222 inclusive. Whenever the interest due a claimant or health care provider
223 pursuant to this section is less than one dollar, the insurer shall deposit
224 such amount in a separate interest-bearing account in which all such
225 amounts shall be deposited. At the end of each calendar year each such
226 insurer shall donate such amount to The University of Connecticut
227 Health Center.

228 (B) Each insurer, or other entity responsible for providing payment
229 to a health care provider pursuant to an insurance policy subject to this
230 section, shall pay claims not later than forty-five days after receipt by
231 the insurer of the claimant's proof of loss form or the health care
232 provider's request for payment filed in accordance with the insurer's
233 practices or procedures, except that when there is a deficiency in the
234 information needed for processing a claim, as determined in
235 accordance with section 38a-477, the insurer shall (i) send written
236 notice to the claimant or health care provider, as the case may be, of all
237 alleged deficiencies in information needed for processing a claim not
238 later than thirty days after the insurer receives a claim for payment or
239 reimbursement under the contract, and (ii) pay claims for payment or
240 reimbursement under the contract not later than thirty days after the
241 insurer receives the information requested.

242 (C) As used in this subdivision, "health care provider" means a
243 person licensed to provide health care services under chapter 368v,
244 chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a to 384c,
245 inclusive, or chapter 400j.

246 (16) Failure to pay, as part of any claim for a damaged motor vehicle
247 under any automobile insurance policy where the vehicle has been
248 declared to be a constructive total loss, an amount equal to the sum of
249 (A) the settlement amount on such vehicle plus, whenever the insurer
250 takes title to such vehicle, (B) an amount determined by multiplying

251 such settlement amount by a percentage equivalent to the current sales
252 tax rate established in section 12-408. For purposes of this subdivision,
253 "constructive total loss" means the cost to repair or salvage damaged
254 property, or the cost to both repair and salvage such property, equals
255 or exceeds the total value of the property at the time of the loss.

256 (17) Any violation of section 42-260, by an extended warranty
257 provider subject to the provisions of said section, including, but not
258 limited to: (A) Failure to include all statements required in subsections
259 (c) and (f) of section 42-260 in an issued extended warranty; (B)
260 offering an extended warranty without being (i) insured under an
261 adequate extended warranty reimbursement insurance policy or (ii)
262 able to demonstrate that reserves for claims contained in the provider's
263 financial statements are not in excess of one-half the provider's audited
264 net worth; (C) failure to submit a copy of an issued extended warranty
265 form or a copy of such provider's extended warranty reimbursement
266 policy form to the Insurance Commissioner.

267 (18) With respect to an insurance company, hospital service
268 corporation, health care center or fraternal benefit society providing
269 individual or group health insurance coverage of the types specified in
270 subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469,
271 refusing to insure, refusing to continue to insure or limiting the
272 amount, extent or kind of coverage available to an individual or
273 charging an individual a different rate for the same coverage because
274 such individual has been a victim of family violence.

275 (19) With respect to an insurance company, hospital service
276 corporation, health care center or fraternal benefit society providing
277 individual or group health insurance coverage of the types specified in
278 subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-
279 469, refusing to insure, refusing to continue to insure or limiting the
280 amount, extent or kind of coverage available to an individual or
281 charging an individual a different rate for the same coverage because
282 of genetic information. Genetic information indicating a predisposition
283 to a disease or condition shall not be deemed a preexisting condition in

284 the absence of a diagnosis of such disease or condition that is based on
 285 other medical information. An insurance company, hospital service
 286 corporation, health care center or fraternal benefit society providing
 287 individual health coverage of the types specified in subdivisions (1),
 288 (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, shall not be
 289 prohibited from refusing to insure or applying a preexisting condition
 290 limitation, to the extent permitted by law, to an individual who has
 291 been diagnosed with a disease or condition based on medical
 292 information other than genetic information and has exhibited
 293 symptoms of such disease or condition. For the purposes of this
 294 subsection, "genetic information" means the information about genes,
 295 gene products or inherited characteristics that may derive from an
 296 individual or family member.

297 (20) Any violation of sections 38a-465 to 38a-465m, inclusive.

298 (21) With respect to a managed care organization, as defined in
 299 section 38a-478, failing to establish a confidentiality procedure for
 300 medical record information, as required by section 38a-999.

301 (22) Any violation of section 38a-478m.

302 (23) With respect to an insurance company, hospital service
 303 corporation, health care center or fraternal benefit society providing
 304 individual or group health insurance coverage of the types specified in
 305 section 38a-469, offering or providing any incentive, financial or
 306 otherwise, to any person for denying enrollees' health care claims or
 307 based on the number of denials such person makes.

This act shall take effect as follows and shall amend the following sections:		
Section 1	January 1, 2009	38a-816

INS *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 09 \$	FY 10 \$
Insurance Dept.	GF - Revenue Gain	Potential Minimal	Potential Minimal

Note: GF=General Fund

Municipal Impact: None

Explanation

This bill could result in a minimal revenue gain to the General Fund from fines collected by the Department of Insurance. It makes offering or providing incentives to deny health care claims an unfair or deceptive insurance practice. Under current law, an entity committing an unfair or deceptive insurance practice may be ordered to pay a maximum fine of \$10,000 per violation.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to the number of fines ordered and collected for such unfair and deceptive insurance practices.

OLR Bill Analysis**sSB 482*****AN ACT CONCERNING HEALTH CARE CLAIMS.*****SUMMARY:**

This bill makes it an unfair and deceptive insurance practice for certain entities to offer or provide any financial or other incentive to any person (1) for denying health care claims or (2) based on the number of claims the person denies. It applies this provision to insurers, HMOs, hospital service corporations, and fraternal benefit societies issuing group or individual health insurance coverage.

Under existing law, the fines for committing an unfair and deceptive insurance practice are as follows: (1) up to \$1,000 for each violation, with a \$10,000 maximum; (2) up to \$5,000 for each violation committed knowingly, with a \$50,000 maximum in any six-month period; and (3) up to \$10,000 for violating a cease and desist order. Fines are in addition to, or in lieu of, license suspension or revocation.

EFFECTIVE DATE: January 1, 2009

BACKGROUND***Related Bill***

sHB 5159, which the Insurance and Real Estate Committee reported favorably, increases the fines for committing an unfair and deceptive insurance practice, as follows: (1) up to \$5,000 for each violation, with a \$50,000 maximum; (2) up to \$25,000 for each violation committed knowingly, with a \$250,000 maximum in any six-month period; and (3) up to \$50,000 for violating a cease and desist order.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 19 Nay 0 (03/11/2008)